# Chapter 10: Sexual Assault


### Abstract

Rape is the most underreported crime in America and in South Carolina. Significant changes to improve the treatment of sexual assault victims have occurred in the last three decades. The impact of reforms, led by the women's movement, can be seen in the legal, medical, mental health, and victim services arenas. During the 1970s, the first rape crisis center was established. The treatment of victims in the criminal justice system was questioned, and hundreds of laws were passed to protect rape victims in the courts. Medical protocols have been developed and widely accepted. The mental health impact of rape is now well documented in the literature, and the practices of mental health professionals have improved. Although the treatment of rape victims today is vastly different from two decades ago, many victims still do not report the crime, and they do not receive the assistance and treatment they need.


### Learning Objectives

Upon completion of this chapter, students will understand the following concepts:

- The definitions of rape and sexual assault.
- The major ways that rape incidence and prevalence are measured and the implications of these findings.
- Scope and key characteristics of rape cases.
- The mental and physical health consequences of rape and how these consequences affect for reporting.
- Comprehensive approach to responding to rape victims.
- Roles and responsibilities of the criminal or juvenile justice system and other professionals in protecting the rights of rape victims and dealing with rape cases.
- The management of sex offenders in the community.
- Recent statutory changes and areas of protection that still need to be strengthened.
- Promising practices that address sexual assault and rape victims' needs.

## Statistical Overview

As noted elsewhere (Crowell and Burgess 1996, chap. 1; Kilpatrick 1983; Kilpatrick et al. 1998), obtaining an accurate measurement of rape and other types of sexual assault poses many challenges. The number of rapes and other types of sexual assault depends on how these crimes are defined and how they are measured. These definitional and measurement issues will be discussed subsequently, but the important thing to consider in reviewing the following statistics is that they are derived from different sources and often measure different things using different methodologies. A discussion of strengths and weaknesses of various data sources for rape statistics is provided in the Rape in South Carolina: A Report to the State (Kilpatrick & Ruggiero 2003).

- According to the Federal Bureau of Investigation's *Uniform Crime Reports*, an annual statistical compilation of crimes reported to law enforcement agencies across the nation, 93,103 forcible rapes were reported in 1998 (FBI 17 October 1999, 24).
- The 1997 National Crime Victimization Survey, which includes both reported and unreported crimes, found that despite a decline of 7% in the nation's crime rate in 1997, rates of rape and sexual assault did not decline (BJS 1998).
- The National Women's Study (NWS), a longitudinal survey of a national probability sample of adult women funded by the National Institute of Drug Abuse, found that approximately 13% of adult women had been victims of completed rape during their lifetime (Kilpatrick, Edmunds, & Seymour 1992; Resnick et al. 1993). In the one year period between the second and third interviews, 0.6% of adult women, or an estimated 683,000 women were victims of rape (Kilpatrick, Edmunds, & Seymour 1992). In the two years between the first and third interviews, 1.2% of the adult participants in the NWS were raped, producing an estimate that 1.1 million women were raped in the United States during this two year period (Kilpatrick et al. 1997).
- Using a definition of rape that includes forced vaginal, oral, and anal sex, the National Violence Against Women Survey found that one out of six U.S. women and one out of thirty-three U.S. men have experienced an attempted or completed rape as a child and/or adult. According to estimates, approximately 1.5 million women and 834,700 men are raped and/or physically assaulted by an intimate partner annually in the United States (Tjaden & Thoennes 1998, 2, 5).
- The National Crime Victimization Survey found that in 1996 more than two-thirds of rape/sexual assaults committed in the nation remained unreported (Ringel 1997, 3).
- The National Survey of Adolescents (NSA), a National Institute of Justice-funded study of a national household probability sample of 4,023 twelve- to seventeen-year-old adolescents, found that 8.1% of U.S. adolescents had been victims of at least one sexual assault (Kilpatrick and Saunders

1997; Kilpatrick et al. 2000). This indicates that an estimated 1.8 million 12- to 17-year-olds have been sexually assaulted.

- Injury sustained by females during rapes and/or sexual assaults affected whether law enforcement was notified. Females who suffered physical injury in addition to the injury suffered from the rape or sexual assault reported 37% of those victimizations; while only 22% of rapes and sexual assault without an additional physical injury were reported (Craven 1994, 5).

## Introduction

Although rape has occurred throughout history, the anti-rape movement in the United States did not begin until the early 1970s. In 1972, the first rape crisis centers were established in San Francisco, CA (Bay Area Women Against Rape) and Washington, DC (DC Rape Crisis Center), both of which are still in existence today. These grassroots centers were an outgrowth of the women's movement, which recognized that rape was an all too common part of women's lives and that it had a devastating impact on women's health and freedom. The explicit goals of rape crisis centers were to educate society about the problem of rape, to change society in ways that could help prevent rape, and to improve the treatment of rape victims. The first rape crisis centers in South Carolina were established in 1974 in Charleston and Greenville.

In the three decades since its birth, the anti-rape movement has accomplished many of its goals. Major accomplishments include widespread reform of rape statutes and other related legislation, improvements in the criminal and juvenile justice system's treatment of rape victims, greater understanding of the scope and impact of rape, improved medical and mental health services for rape victims, and better funding for rape crisis centers and others who provide services and advocacy for rape victims. Despite this progress, much remains to be done. Most rapes still go unreported (Kilpatrick, Edmunds, & Seymour 1992; Crowell & Burgess 1996; Ringel 1997), resulting in cases that can never be detected, investigated, or prosecuted. Although vast improvements in forensic, law enforcement, and prosecution protocols have been made, further improvements are needed. Too few victims who sustain rape-related mental or physical health problems obtain effective treatment. The fact that well over a million people of all ages are raped each year in the U.S. suggests that efforts to prevent rape have not been entirely successful.

This chapter will address the following questions: (1) How are rape and other forms of sexual assault defined? (2) What are the scope and mental health impact of rape? (3) What are victims' key concerns? and (4) How can we best address these concerns to improve victims' cooperation? One major focus of the chapter is to identify how the answers to these questions can be used to improve the treatment of rape victims by the criminal and juvenile justice systems as well as by victim assistance and allied professionals. A second focus is to identify

ways that this information could be used to improve the investigation and prosecution of rape cases.

## Definitions of Sexual Assault and Rape

### EVOLUTION OF THE DEFINITION OF SEXUAL ASSAULT AND RAPE

Several authors (Estrich 1987; Koss 1993) have observed that many people still believe that rape occurs only when a total stranger attacks an adult woman using overwhelming force. Using this definition, boys or men cannot be raped; girls and adolescents cannot be raped; no one can be raped by someone they know well; and forced oral or anal sex does not constitute rape. Thus attempts to discuss the topic are often frustrating because many people define rape differently.

Before the 1960s, the legal definition of rape was generally a common law definition used throughout the United States that defined rape as *"carnal knowledge* of a woman not one's wife by force or against her will." In 1962, the United States Model Penal Code (MPC) was established, thus updating the definition of rape. The MPC defined rape as: "A man who has sexual intercourse with a female not his wife is guilty of rape if . . . he compels her to submit by force or threat of force or threat of imminent death, serious bodily injury, extreme pain, or kidnapping" (Epstein & Langenbahn 1994, 7). In addition to *limiting* the definition of rape to a crime against a *woman*, this code was also very narrow for the following reasons:

- It retained a marital-rape exemption (not acknowledging rape within marriage or co-habiting couples).
- It focused on the victim's *consent*, rather than the perpetrator's forcible conduct.
- Moreover, the MPC established a "grading system" for the crime of rape and rape offenses. For example, it stated that "rape by a voluntary social companion" was a less serious offense than "rape by a stranger." In addition, it treated the rape of men as a lower felony offense than the rape of women.

In the 1970s and 1980s, extensive rape reform laws were enacted throughout the states, and the legal definition of rape changed dramatically. Michigan's Criminal Sexual Conduct Statute, enacted in 1975, became the national model for an expanded definition of rape. Today, Illinois' Criminal Sexual Assault Statute is considered the national model (Epstein & Langenbahn 1994, 8). Both statutes have the following characteristics that broadly define rape:

- Rape is defined as "gender neutral," which broadens the earlier definitions of rape to include men as well as women.

- They include acts of sexual penetration other than vaginal penetration by a penis.

- They distinguish types of sexual abuse on the basis of the degree of force or threat of force used similar to the "aggravated" versus "simple" assault distinction with physical assaults.

- Threats as well as overt force are recognized as means to overpower the victim.

- In addition, a new category of rape victim, "taking advantage of an incapacitated victim," is included. This category can include mental illness, victims under the influence of drugs, and alcohol intoxication. (Some states require that the perpetrator gave the victim the intoxicant in order to obtain sexual access.)

## THE FEDERAL DEFINITION OF RAPE

In spite of these legislative changes, much of the current debate about what constitutes sexual assault and rape stems from how rape should be defined (Crowell & Burgess 1996).

For purposes of this chapter, rape and other forms of sexual assault are defined using the Federal Criminal Code (Title 18, Chapter 109A, Sections 2241-2243) as a guide. Although criminal statutes differ somewhat across states in their definitions, the Federal Code is national in scope. For example, in addition to incorporating the reform provisions discussed above-gender neutrality and incorporation of a broad definition of acts of sexual abuse--the Federal Criminal Code definition includes the following points:

- Distinguishes between types of sexual abuse on the basis of the degree of force or threat of force used, similar to the aggravated versus simple assault distinction of physical assaults.

- Does not use the term "rape," and does not require the victim to label the act as rape in order to meet the elements of a crime.

The 1986 federal statute defines two types of sexual assault:

- Aggravated sexual abuse.

- Sexual abuse.

***Aggravated sexual abuse.***
*Aggravated sexual abuse by force or threat of force*. When a person "knowingly causes another person to engage in a sexual act" . . . "or attempts to do so by

*Aggravated sexual abuse by other means*. When a person "knowingly renders another person unconscious and thereby engages in a sexual act with that other person; or administers to another person by force or threat of force, or without the knowledge or permission of that person, a drug, intoxicant, or other similar substance and thereby:

- Substantially impairs the ability of that person to appraise or control conduct; and
- Engages in a sexual act with that person."

*Aggravated sexual abuse with a child:* When a person "knowingly engages in a sexual act with another person who has not attained the age of twelve years, or attempts to do so."

Clearly the definition for aggravated sexual abuse by force or threat of force is analogous to what is usually called *forcible rape*. Aggravated sexual abuse of children is a serious form of what is generally called *statutory rape*. However, aggravated sexual abuse by other means is a type of nonforcible rape whose perpetrator "shall be fined . . . imprisoned for any term of years or life, or both."

***Sexual abuse.*** The Federal Criminal Code definition of sexual abuse includes two types of acts:

- Causing another person to engage in a sexual activity by threatening or placing that person in fear.
- Engaging in a sexual act if that person is incapable of declining participation in or communicating unwillingness to engage in that sexual act.

*Abusive sexual contact* is defined as when no sexual penetration actually occurred but when "the intentional touching . . . of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person with an intent to abuse, humiliate, harass, degrade, or arouse or gratify the sexual desire of any person" occurs.

*Sexual abuse of a minor or ward* is defined as knowingly engaging in a sexual act with a person between the ages of twelve and fifteen years. (For additional information on sexual crimes against children, see Chapter 11, *Child Victimization.*)

## IMPLICATIONS OF DEFINITIONS

While great reforms have been made, these criminal code-based definitions of violent crimes addressing sexual assault, abuse, and rape imply the need to know the following information:

- The victim's state of mind at the time of the crime (e.g., fear of death or serious bodily harm) and the victim's crime-related physical and psychological injuries so as to assist in better classification of crimes.

- The proper measurement of rape and sexual abuse, which cannot be assessed without information about the types of unwanted sexual acts that are involved, the types of force or the coercion used by the perpetrator, and the ages of the victim and the perpetrator.

### Measuring Rape and Other Types of Sexual Assault

As a part of the Violence Against Women Act of 1994, the U.S. Congress directed the National Research Council to develop a research agenda on violence against women. The National Academy of Sciences convened a panel of experts to implement this directive; an important aspect of the panel's charge was to evaluate the nature and scope of violence against women, including sexual violence. Chapter 2 of the panel's report (Crowell and Burgess 1996) provides an overview of statistics regarding rape and sexual assault taken from official governmental and other data sources. This overview also describes numerous reasons why estimates of how many women are raped frequently differ.

Without getting too technical, estimates of the number of rapes and/or the number of women who have been raped differ because the sources that produce these estimates use different samples, different definitions of rape, different time frames of measurement, different ways of measuring whether a rape has happened, and different units of analysis in reporting statistics. Prior to briefly reviewing some of the major data sources, it is useful to consider a few key distinctions.

First, there is a difference between *rape cases* and *rape victims* because women can be raped more than once. Second, there is a difference between the *incidence* of rape and the *prevalence* of rape. *Incidence* generally refers to the *number of cases* that occur in a given period of time (usually a year), and incidence statistics are often reported as rates (i.e., the number of rape cases occurring per 100,000 women in the population). In contrast, *prevalence* generally refers to the *percentage of women* who have been raped in a specified period of time (i.e., within the past year or throughout their lifetime). Third, there is clearly a difference between estimates based on reported versus nonreported rape cases. Fourth, estimates of rape are derived from two basic types of

sources: official governmental sources and studies conducted by private researchers, which are often supported by grants from federal agencies.

With respect to official governmental sources, the Federal Bureau of Investigation *Uniform Crime Reports* (UCR) provides data on an annual basis about the number of rapes and attempted rapes that were reported to law enforcement agencies in the United States. Clearly, the UCR records only those rapes that were reported to law enforcement agencies and that the agencies in turn reported to the FBI. As noted by Crowell and Burgess (1996), another limitation of the UCR is that it still uses the narrow common law definition of rape (i.e., "carnal knowledge [penile-vaginal penetration only] of a female forcibly and against her will), meaning that other types of rapes as defined by federal law are not reported.

The Bureau of Justice Statistics conducts the National Crime Victimization Survey (NCVS) each year to measure unreported as well as reported crimes, including the crimes of rape and other sexual assaults. The NCVS interviews all residents twelve years or older in approximately 50,000 randomly selected households each six months about crimes that occurred since the last interview. In addition to data about the number of rape *cases* that occur each year and rape *rates* (i.e., number of cases per 10,000 women); the NCVS provides information about the percentage of rape cases that are reported to police as well as about case characteristics. Because the NCVS is primarily designed to measure the number of rapes per year among those ages twelve and older, it cannot measure rapes that occurred prior to the six-month reference period or to children younger than age twelve. The NCVS as well as most other studies cannot measure rapes experienced by women who are homeless.

There are three major nongovernmental studies that provide additional data about the scope, nature, and impact of rape.

- The National Women's Study (NWS), a National Institute of Drug Abuse-funded longitudinal survey of a national probability household sample of 4,008 adult women who were assessed at baseline and for incidence at one- and two-year follow-ups, generated the influential *Rape in America: A Report to the Nation* (Kilpatrick, Edmunds, & Seymour 1992) as well as a number of other peer reviewed scientific publications. The NWS measured rapes and other sexual assaults occurring throughout the victim's lifetime and new cases occurring to adult women during the follow-up period.
- The National Violence Against Women Survey (NVAW), funded by the National Institute of Justice and the CDC, used similar methodology that was pioneered by the NWS and interviewed 8,000 adult women and 8,005 adult men (Tjaden and Thoennes 1998). Rape and sexual assault were measured using screening questions virtually identical to those used in the NWS. Like the NWS, the NVAW measured the lifetime prevalence of rape as well as rapes that occurred during the year prior to the interview.

- The National Survey of Adolescents (NSA) conducted by the National Crime Victims Research and Treatment Center and funded by the National Institute of Justice, conducted interviews with a national household probability sample of twelve- to seventeen-year-old adolescents. These adolescents were interviewed about sexual assaults and other crimes that occurred throughout their lifetimes; information was also gathered about important characteristics of these sexual assault cases (Kilpatrick and Saunders 1997) and about the mental health impact of such experiences.

## Scope and Key Characteristics of Rape Cases

Providing effective services to rape victims, assisting in effective investigation, and facilitating effective prosecution of rape cases cannot occur without accurate information about who rape victims are, and what rape cases are really like. The best way to obtain such information is from the national victimization surveys that have just been described (i.e., the National Crime Victimization Survey, the National Violence Against Women Survey, and the National Survey of Adolescents). These surveys are ideal for this purpose because they include information about unreported, as well as reported, rape cases. Since only a small percentage of rape cases are ever reported to law enforcement, it is critically important that more is learned about the unreported cases and the victims who do not report them.

Prior to describing the scope and case characteristics data, it is important to consider the following general points:

- Any attempts to address the problem of sexual assault must deal with the reality that most sexual assaults are never reported to law enforcement, and that unreported sexual assault cases can never be solved by law enforcement or successfully prosecuted. Encouraging victims to report these unreported cases to law enforcement is critically important because most rapists are recidivists who will continue to rape women and children until they are apprehended, prosecuted, and incarcerated.
- It is extremely important to understand the scope and nature of America's sexual assault problem. Without knowledge of how pervasive sexual assault is, the importance of addressing it may be lost.
- Different types of sexual assault cases require different investigatory and prosecutorial strategies to enhance the prospects of successful prosecution.
- There is considerable variability in the size, funding, and staffing of law enforcement agencies in the United States. Therefore, there is no such thing as a "one size fits all" sexual assault protocol that is equally applicable across all jurisdictions.
- National research indicates that the vast majority of sexual assault cases are never reported to police. The best data on the extent to which crimes

are not reported come from victimization surveys. Such surveys conduct interviews with representative samples of adults and/or adolescents, asking them if they have been victims of crime and if they reported those crimes to police. Some victimization surveys also ask why victims did not report these crimes to police.

- At the national level, two major victimization surveys suggest that most sexual assaults go unreported. The National Crime Victimization Survey, conducted each year by the U.S. Department of Justice, found that only 32% of sexual assault cases were reported to police in 1994. The *Rape in America* survey conducted as a part of the National Women's Study found that only 16% of rape cases were reported to police or other authorities (Kilpatrick, Edmunds and Seymour 1992). Data from the National Survey of Adolescents indicated that only 14.3% of sexual assault cases had been reported. Thus, these national studies indicate that only between 14% and 32% of all sexual assaults or rapes are ever reported to police.
- Analysis of national studies suggests that victims are reluctant to label their experience rape when the perpetrator is a spouse, boyfriend, or acquaintance (Acierno, Resnick, and Kilpatrick 1997). If the victim does not see the act as a crime, she will not report it to the police.
- Victims with disabilities are even less likely to report sexual assaults (Cole 1991). They are frequently more socially isolated than their nondisabled peers and may not be viewed as credible should a report be made. The assailant is often a family member or caretaker, so the victim may fear abandonment should he/she report.
- When a woman or girl does not report a rape, the stakes are high. Not only does she not get justice in her case, but the rapist also remains free to rape others. *Rape in America* (Kilpatrick, Edmunds, & Seymour 1992) described why nonreporting is a major public safety problem. A study of unincarcerated sex offenders conducted by Dr. Gene Abel and his colleagues found that 126 men admitted that they had committed rape. *These 126 rapists had committed a total of 907 rapes involving 882 different victims. The average number of different victims per rapist was seven* (Abel et al. 1987). Clearly, any attempt to address America's sexual assault problem must first address this nonreporting problem, which constitutes a serious public safety problem for the citizens of the United States.
- When a victim does report a rape, the stakes are also high. Victims often fear retaliation from the offender, his family, and/or peers. They may also fear the response of the criminal justice system given the circumstances of the rape. Victims are most likely to receive sensitive treatment when they are "good victims," meaning that they were raped by a stranger who used a weapon and were sober at the time of the assault (Campbell 1998). Analysis of the data obtained by the National Crime Victimization Surveys suggests that female victims are hesitant to report rapes that do not fit the classic scenario--stranger rape with injuries. Male victims are likely to report only if they sustained severe bodily injury (Pino and Meier 1999).

## The Scope of the Rape and Sexual Assault Problem

As was previously described in the Statistical Overview section, the National Violence Against Women (NVAW) survey produced an estimate that 14.8% of adult women in the U.S. had been raped sometime during their lives and that another 2.8% had been victims of an attempted rape (Tjaden and Thoennes 1998). For adult men, comparable lifetime prevalence estimates for rape and attempted rape were 2.1% and 0.9% respectively. The National Women's Study (NWS) found that 12.7% of adult women had been victims of completed rape and 14.3% had been victims of other types of sexual assault. The National Survey of Adolescents (NSA) estimated that 13.0% of female adolescents and 3.4% of male adolescents had been victims of a sexual assault at some point during their short lives (Kilpatrick & Saunders 1997). All of these studies confirm that the lifetime prevalence of rape is such that millions of adolescents and adults in the U.S. have been raped. Women are at greater risk than men for such assaults.

Data from the NWS and NSA also indicate that revictimization is an important problem for many women and adolescents. Thirty-nine percent of rape victims in the NWS were raped more than once, and 41.7 percent of the adolescent sexual assault victims in the NSA said that they were sexually assaulted more than once.

## National Research on Rape

Due to the many myths, misconceptions, and social attitudes about rape and sexual assault, the National Center for Victims of Crime, in partnership with the National Crime Victims Research and Treatment Center at the Medical University of South Carolina, published *Rape in America: A Report to the Nation* in 1992 (Kirkpatrick, Edmunds, & Seymour). The report was based on The National Women's Study-funded by the National Institute of Drug Abuse--a three-year longitudinal study of a national probability sample of 4,008 adult women, (age eighteen or older), 2,008 of whom represented a cross-section of all adult women and 2,000 of whom were a sample of younger women between the ages of eighteen and thirty-four.

Providing the first national empirical data about forcible rape of women in America, the study found:

- Seven-tenths of 1% of all women surveyed had experienced a completed forcible rape in the past year. This equates to an estimated 683,000 adult American women who were raped during a twelve-month period.

- 13% of women had been victims of at least one completed rape in their lifetimes.

- Based on U.S. Census estimates of the number of adult women in American, one out of every eight adult women, or at least, 12.1 million

American women, had been the victim of forcible rape sometime in her lifetime.

- While 56%, or an estimated 6.8 million women experienced only one rape, 39%, or an estimated 4.7 million women were raped more than once, and 5% were unsure as to the number of times they were raped (Kilpatrick, Edmunds, & Seymour 1992).

Prior to this study, national information about rape was limited to data on reported rapes from the *FBI Uniform Crime Reports* or data from the Bureau of Justice Statistics National Crime Survey (NCS) on reported and nonreported rapes occurring in the past year. The number of rapes per year in *Rape in America* were approximately five times higher than either the Uniform Crime Reports or the NCS. Recently, the NCS has been redesigned due to concerns that it failed to detect a substantial proportion of rape cases.

**AGE OF RAPE VICTIMS**

The National Women's Study (NWS) found that "rape in America is a tragedy of youth," with the majority of rape cases occurring during childhood and adolescence:

- 29% of all forcible rapes occurred when the victim was less than eleven years old.
- 32% occurred when the victim was between the ages of eleven and seventeen.
- 22% occurred between the ages of eighteen and twenty-four.
- 7% occurred between the ages of twenty-five and twenty-nine.
- 6% occurred when the victim was older than twenty-nine years old.

The National Violence Against Women Survey (NVAW) found that "rape is primarily a crime against youth" (Tjaden and Thoennes 1998, 6):

- 21.6% of first or only rape cases experienced by women occurred before age twelve.
- 32.4% occurred between the ages of twelve and seventeen.
- 29.4% occurred between the ages of eighteen and twenty-four.
- 16.6% occurred at age twenty-five or greater.

*Note:* The NWS data represent a breakdown of victims' ages at the time of *all* rape cases whereas the NVAW data are a breakdown of age at the time of the first rape only.

The National Study of Adolescents (NSA) also provided information about 462 cases at the time the sexual assault was experienced by twelve- to seventeen-year-old adolescents (Kilpatrick November 1996):

- 29.9% had been assaulted before age eleven.
- 16.3% between the ages of eleven and twelve.
- 20.8% between the ages of thirteen and fourteen.
- 20.8% between the ages of fifteen and sixteen.
- 1.7% at age seventeen.

*Note:* In the remaining 8.7% of cases, victims were not sure or refused to provide age data.

**RELATIONSHIP OF THE VICTIM TO THE OFFENDER**

The National Women's Study (NWS) dispelled the common myth that most women are raped by strangers:

- Only 22% of rape victims were assaulted by someone they had never seen before or did not know well.
- 9% of victims were raped by husbands or ex-husbands.
- 11% were raped by their fathers or stepfathers.
- 10% were raped by boyfriends or ex-boyfriends.
- 16% were raped by other relatives.
- 29% were raped by nonrelatives, such as friends and neighbors.

In addition to the data just presented, the NWS also gathered information about new cases of rape that happened to adult women during the two year follow-up period. Thus, these data on the forty-one such cases provide excellent information about the breakdown for new rapes that are experienced by adult women (Kilpatrick et al. 1998).

- 24.4% of offenders were strangers.
- 21.9% were husbands.

- 19.5% were boyfriends.
- 9.8% were other relatives.
- 9.8% were friends.
- 14.6% were other nonrelatives.

The National Violence Against Women (NVAW) survey used different categories for victim-perpetrator relationships but reported similar findings with respect to the types of perpetrators that are most prevalent in rape cases occurring after the age of eighteen.

- 76% of perpetrators in rape cases were intimate partners (i.e, current and former spouses, cohabiting partners, dates, and boyfriends/girlfriends).
- 16.8% were acquaintances.
- 14.1% were strangers.
- 8.6% were relatives other than spouses.

In summary, only a small percentage of cases involved perpetrators who were strangers; most were intimate partners.

The National Survey of Adolescents (NSA) provides a different perspective because it provides data on cases during childhood and adolescence (Kilpatrick 1996).

- 32.5% of perpetrators were identified as friends.
- 23.2% were strangers.
- 22.1% were relatives (fathers, stepfathers, brothers, sisters, grandparents, etc.).
- 18.1% were other nonrelatives known well by the victim.

## DEGREE OF PHYSICAL INJURY

Another common misconception about rape is that most victims sustain serious physical injuries. The statistics show the following:

- 70% of rape victims reported no physical injuries.
- 4% sustained serious physical injuries.
- 24% received minor physical injuries.

- Of considerable importance is the fact that many victims who did not sustain physical injuries nonetheless feared being seriously injured or killed during the rape. Almost half of all rape victims (49%) described being fearful of serious injury or death during the rape.

Not surprisingly, the percentage of new rape cases resulting in physical injuries (*N*=41) experienced by adult women in the NWS was somewhat higher than cases that included childhood and adolescent rapes (Kilpatrick et al. 1998).

- 9.8% of victims reported serious physical injuries.
- 46.3% sustained minor injuries.
- 43.9% sustained no physical injuries.
- 58.5% said that they were fearful of serious injury of death.

The NVAW survey data provide a detailed breakdown of physical injuries sustained and medical treatment received in the recent cases of rapes women experienced since the age of 18.

- 31.5% of women sustained some physical injuries.
- Only 35.6% of victims with injuries received medical treatment.

In the NSA, 85.5% of child and adolescent cases resulted in *no* physical injuries. Only 1.3% of victims reported serious injuries, and 11% reported minor injuries (Kilpatrick 1996).

### Implications Regarding the Scope and Characteristics of Rape for the Investigation and Prosecution of Rape Cases

There are three major implications of the aforementioned findings. First, information from all of these sources provides compelling evidence that most rapes are not committed by strangers, but by individuals well-known to their victims. This finding has profound implications for how rape cases should be investigated and prosecuted. If most victims know the identity of their perpetrators, then the key investigative issue is not finding out "who did it" by collecting evidence that permits the investigator to identify the perpetrator. Instead, most cases are likely to require evidence that permits refutation of claims by the alleged perpetrator that the sexual activity was consensual and did not constitute sexual battery. Known perpetrators are unlikely to use "misidentification" defenses because forensic examinations can conclusively link the perpetrator to the assault.

Second, Susan Estrich (1987) notes that successful prosecution of rape cases often requires victims to produce evidence of physical injuries to prove that they did not consent.

> The fact that the vast majority of rape victims do not sustain major physical injuries also has clear implications for investigation and prosecution of rape cases. The first implication is that most victims will not exhibit overt physical injuries that most people think are characteristic of violent sexual attacks. Therefore, many people are likely to conclude that the victim consented unless physical injuries are present. The second implication is that forensic examinations must focus on detecting evidence of physical injuries that are not consistent with consensual sexual activity. A third implication is that law enforcement, prosecutors, judges, jurors and paroling authorities need to be informed about these physical injury data.

Third, all of these data indicate that most rapes other than sexual assaults involve relatively young victims--not adult women as most people believe. This suggests that separate investigative protocols should be established for adult and child victims.

### Implications for Sexual Assault Forensic Medical Examinations

In sexual assault cases, the victim's body is the primary "crime scene," and the forensic medical examination is an extremely important part of evidence collection. Based on the victim's report of what types of sexual acts were involved, the forensic exam collects evidence from the victim's body that can be used to establish that sexual activity occurred, identify who committed the sexual act, and establish whether the sexual act produced physical injuries consistent with forced sex.

As was previously noted, the typical rape involves a perpetrator who is known by the victim and whose attack does not produce major physical injuries. In these cases, the key issue in the forensic exam is *not* establishing the alleged perpetrator's identity because that is already known. The exam needs to collect evidence documenting that a sex act occurred to counter the possible defense that a suspect never had sex with the victim. The exam also needs to collect DNA or other evidence that can be used to prove that the sexual act occurred and that the defendant was responsible for it. The only remaining defense a suspect can use if the "nothing happened" and "misidentity" defenses are refuted by forensic evidence is a "consent" defense. Thus, the forensic examination must collect evidence that speaks to the issue of whether the sexual activity was consensual or not. Evidence that physical injuries occurred to the victim's vulva, vagina, or anus that are inconsistent with consensual activity would be a powerful tool to refute a consent defense. Therefore, it is extremely important that the forensic medical exam be conducted in such a way that such physical injuries

can be detected because such forensic evidence is one of the few ways that a consent defense can be refuted.

Most sexual assault protocols for adult victims do not include state-of-the-art procedures for detecting physical injuries to the victim's vulva, vagina, or anus. Fortunately, new technology exists that has the potential to dramatically increase detection of physical injuries. The colposcope is a standard tool used by gynecologists for the evaluation of microscopic cervical, vaginal, or vulvar disease. Using a colposcope, the vulva, vagina, cervix, and/or anus can be examined at magnifications over thirty times the actual size. This permits detection of small or microscopic tears, bruises, or abrasions that are not visible to the naked eye. Colposcopic examination provides a much more objective and sensitive way of seeing and documenting genital, anal, and other injuries in sexual assault victims.

The ideal acute sexual assault examination protocol has two components. The first part is similar to the existing sexual assault exam protocol, which is conducted within seventy-two hours after the assault. However, the protocol is changed to include a colposcopic exam. The second part of the forensic exam protocol also includes a colposcopic exam and is conducted four to six weeks after the assault. The purpose of this second part of the forensic exam is to collect evidence of the victim's recovery from the physical injuries detected during the first exam. This evidence of recovery can only be documented if the two exams are conducted, and provide a strong basis for an expert examiner to testify about recovery from injuries that are not consistent with consensual sex.

A final advantage of the colposcope is that technology exists to take photographs or make videotapes of what is visualized. Thus, it is possible to have documentation in the form of color photographs and/or videotapes of the physical injuries detected. This visual documentation of injuries sustained by sexual assault victims has been described as having a powerful impact on jurors and on defendants, many of whom have entered guilty pleas when confronted with this evidence that "consensual sex" produced physical injuries consistent with the victim's statement.

Sexual Assault Nurse Examiner (SANE) programs (discussed more fully herein at page 25) have developed in recent years in many jurisdictions throughout the country in response to the need for victim-sensitive treatment in gathering crucial medical/evidentiary information in forensic medical examinations of rape victims.

## NEED FOR MULTIDISCIPLINARY MEDICAL CARE PROGRAMS ADDRESSING THE NEEDS OF RECENT RAPE VICTIMS

Initial medical examination immediately post-rape is recommended for sexually transmitted diseases and for provision of prophylactic treatment available to treat specific sexually transmitted diseases. Such examinations also include

counseling and provision of emergency contraception in relevant cases (CDC 1998). It is also recommended that rape victims be seen for follow-up medical examination to assess new infections that may be related to assault and counsel victims about STDs and hepatitis B as well as to treat existing diseases. CDC guidelines recommend offering follow-up care at two weeks post-assault for repeat STD testing and additional blood testing for syphilis and HIV that can be repeated at six, twelve and twenty-four weeks post-assault. While these guidelines for initial and medical care follow-up have been recommended (Young et al. 1992), the reality is that in most states provision of initial post-rape medical care is financially supported by the state or by third party payment from sources like Crime Victims Compensation in cases in which a formal report of rape has been made to police within a set number of hours post-assault (*Crime Victims Compensation Quarterly*, 1995). This is the case in South Carolina.

Since the vast majority of rape victims do not report the assault to police (Kilpatrick, Edmunds, & Seymour 1992), this means that they would be ineligible for subsidized medical treatment of acute injuries. For those rape victims who do report a rape to police, the emphasis has been on provision of immediate medical follow-up. For most states there are no specific provisions for medical follow-up of women in the weeks following the assault.

Currently there are some model programs that include follow-up medical care for victims (Young et al. 1992; Holmes, Resnick, & Frampton 1998). Holmes provides a description of the Sexual Assault Follow-up Evaluation (SAFE) clinic program developed at the Medical University of South Carolina. This program provides medical care to women regardless of whether or not they have reported an assault to police. In addition, follow-up care is provided at six weeks and six months post-assault. Such care includes re-assessment and treatment of sexually transmitted diseases and long term follow-up blood testing for HIV and hepatitis B. In a sample of over 300 women and adolescents Holmes et al. noted that the follow-up clinic provided an opportunity to also address women's mental health and social service needs as well as to counsel them about medical and other concerns post-rape. Such education about health risk behaviors and normalization of physical arousal symptoms might help to prevent later health problems and inappropriate use of medical care (i.e., emergency room visits). The SAFE clinic includes a multidisciplinary team of OB-GYN professionals, staff from the National Crime Victims Research and Treatment Center, and staff from the local rape crisis center, People Against Rape (PAR). The team provides for easy referral for mental health treatment and for PAR follow-up of additional referral or counseling needs.

Another multidisciplinary aspect of the program at the Medical University of South Carolina is the development and evaluation of a brief video-based intervention to help prepare women for the acute postrape medical exam and to provide education and instruction designed to reduce postrape symptoms of PTSD, substance abuse, panic, and depression. Psychologist Dr. Heidi Resnick

and colleagues at the National Crime Victims Research and Treatment Center have implemented this program in coordination with the local rape crisis center (People Against Rape), Dr. Melisa Holmes of the MUSC Obstetrics and Gynecology Department, medical personnel at the MUSC Trauma Center, and the MUSC General Clinical Research Center (GCRC).

Major ideas that led to this project included the fact that all women who report a rape are seen for medical care within hours of their assault. Thus, this medical care setting provides an opportunity to provide early intervention that could prevent some of the negative mental health consequences of rape. In addition, for some women it may be the only opportunity to provide such an intervention since many women may not seek out needed services or may do so only many years later. A second factor that led to the project development was that rather than reducing anxiety the medical exam contains many cues that might actually increase rape victims' distress. Previous data indicated that women's initial post-rape distress is a strong predictor of longer term distress. Therefore, an intervention that could reduce distress at the time of the medical exam might help women in their longer term recovery. Evidence for the usefulness of brief education plus instructional approaches in an emergency room setting also influenced the content of the intervention as well as the need to address a range of mental health problems that rape victims are at increased risk of developing in the aftermath of assault.

To address these concerns, an acute time-frame hospital-based video intervention was developed to: (1) minimize anxiety during forensic rape exams, and (2) prevent post-rape posttraumatic stress disorder (PTSD), depression, and substance abuse. This video-based intervention has been implemented at a sexual assault outpatient exam room located at a central hospital serving rape victims.

Victims are first seen in the emergency room of the hospital to determine whether they require additional treatment of physical injuries. All study participants complete informed consent at the time of the emergency room exam which takes place within 72 hours post-rape. Participation in the study is completely voluntary and does not affect receipt of medical care in any way. Participating women are randomly assigned either to a video or standard treatment as usual condition at the time of the exam. Pre- and post-medical exam measures of anxiety are administered at the time of the emergency room exam. In addition, women are reinterviewed at six weeks and six months post-rape to determine mental health status at those time points. Preliminary data (Resnick et al. 1999) indicate that women participating in the video intervention condition were significantly less distressed following the medical examination than women in the standard condition group, after controlling for pre-exam levels of distress/anxiety. Data also indicate that distress following the medical exam is significantly correlated with all measures of mental health functioning at six weeks post-rape. Preliminary data also support the efficacy of providing an intervention at the

acute post-rape medical exam that may reduce anxiety in the medical setting and that may be related to reduction of some long-term mental health problems among rape victims.

## Reasons for Nonreporting and How to Increase Reporting

The fact that most rape cases are never reported to police means that most rapists are never detected, arrested, or successfully prosecuted. *Rape in America* (Kilpatrick, Edmunds, & Seymour 1992) included information on rape victims' concerns that are relevant to why most victims are reluctant to report. Major concerns identified by victims were being blamed by others, their families finding out about the rape, other people finding out, and their names being made public by the news media. A rape victim with these concerns would likely have substantial reservations about reporting the rape to police. However, it is reasonable to assume that addressing these concerns might encourage victims to report.

The report also described the results of a national survey of 522 organizations that provided crisis counseling services to victims of rape, at least some of whom did not report to police. Representatives from these agencies provided a list of actions and activities that would be effective in increasing women's willingness to report rapes to police:

- Educate the public about acquaintance rape (99%).
- Pass laws protecting confidentiality and disclosure of victims' names (97%).
- Expand counseling and advocacy services (97%).
- Provide mandatory HIV testing for indicted defendants (80%).
- Provide free pregnancy counseling and abortions (77%).
- Provide confidential, free testing for HIV and STDs (57%).

Sexual assaults of men are "silent crimes" that are even less likely to be reported than rapes of women. Heterosexual men often fear that if they report being raped by a man, it may be thought that they are gay, and they may feel emasculated by the assault (TCLEOSE 2000). Men are likely to report a sexual assault only if they sustain severe bodily harm suggesting that they attempted to thwart the attack (Pino & Meier 1990).

Efforts to increase the reporting of rape cases must be as big a priority as the effective processing of cases that are reported. This effort will require a great deal of public education about rape in general and about acquaintance rape in particular. It will also require making sure that rape victims know that they can get

the supportive services they need and that their privacy will be protected to every extent that is legally possible. It also requires a public education campaign that stresses the importance of reporting all rape cases.

## The Mental Health Impact of Rape

The National Women's Study produced dramatic confirmation of the mental health impact of rape by determining comparative rates of several mental health problems among rape victims and women who had never been victims of rape. The study ascertained whether rape victims were more likely to experience these devastating mental health problems than women who had never been crime victims (Kilpatrick, Edmunds, & Seymour 1992).

### POSTTRAUMATIC STRESS DISORDER

The first mental health problem examined was posttraumatic stress disorder (PTSD), an extremely debilitating mental health disorder occurring after a highly disturbing traumatic event, such as military combat or violent crime.

- Almost one-third (31%) of all rape victims developed PTSD sometime during their lifetimes and more than one in ten rape victims (11%) still had PTSD at the time of assessment.
- Rape victims were 6.2 times more likely to develop PTSD than women who had never been victims of crime (31% vs. 56%).

- Rape victims were also 5.5 times more likely to have current PTSD than their counterparts who had never been victims of crime (11% vs. 2%).

### OTHER MENTAL HEALTH PROBLEMS

Major depression is a mental health problem affecting many women, not just rape victims. The National Women's Study (NWS) found that 30 percent of rape victims had experienced at least one major depressive episode in their lifetimes and 11 percent of all rape victims were experiencing a major depressive episode at the time of assessment. In contrast, only 10 percent of women never victimized by violent crime had ever had a major depressive episode and only 6 percent had a major depressive episode when assessed (Ibid.).

Thus, rape victims were three times more likely than nonvictims of crime to have ever had a major depressive episode (30% vs. 10%) and were 3.5 times more likely to be currently experiencing a major depressive episode (21% vs. 6%).

Some mental heath problems are life-threatening in nature. When asked if they ever thought seriously about committing suicide, rape victims' answers reflected the following findings: 33 percent of the rape victims and 8 percent of the nonvictims of crime stated that they had seriously considered suicide.

Thus, rape victims were 4.1 times more likely than noncrime victims to have contemplated suicide. Rape victims were also 13 times more likely than noncrime victims to have actually made a suicide attempt (13% vs. 1%). The fact that 13 percent of all rape victims had actually attempted suicide confirms the devastating and potentially life-threatening mental health impact of rape.

Finally, there was substantial evidence that rape victims had higher rates of drug and alcohol consumption and a greater likelihood of having drug and alcohol-related problems than nonvictims. Compared to women who had never been crime victims, rape victims with rape-related PTSD (RR-PTSD) showed the following results:

- 13.4 times more likely to have two or more major alcohol problems (20.1% vs.1.5%).
- 26 times more likely to have two or more major serious drug abuse problems (7.8% vs. 0.3%).

The NWS findings on increased suicide risk provide compelling evidence about the extent to which rape poses a danger to American women's mental health--and even their continued survival (Ibid.). Rape is a problem for America's mental health and public health systems as well as for the criminal and juvenile justice systems.

Rape victims should not be further traumatized by being given an unnecessary mental health label. However, it is imperative that victim advocates be aware of the symptoms of depression and be able to differentiate these symptoms from "normal" PTSD. It is the role of the victim advocate to make referrals for treatment when needed. Advocates should become concerned when victims report depressed moods most of the day, no interest in activities that used to give them pleasure, significant weight loss or gain that was not intended, insomnia or oversleeping nearly every day, fatigue, excessive feelings of worthlessness or guilt, lack of concentration, or recurrent thoughts of death, as they are symptoms of severe depression (DSM-IV). When victims express clear suicidal ideation, advocates should take steps to ensure victim safety such as recommending a mental health consultation to determine referral options, including the possible need for hospitalization. Advocates should be aware of which community mental health professionals are competent to deal with victimization issues and make referrals for longer-term interventions appropriately.

## Concerns of Rape Victims

In order to effectively respond to rape victims, service providers and criminal and juvenile justice officials need to understand the major concerns of rape victims. Without accurate information about victims' concerns after rape, it is difficult to create and implement policies and programs to meet their most critical needs.

The National Women's Study (NWS) identified several critical concerns of rape victims (Ibid.). In order to determine if rape victims' concerns have changed over time, the study divided these concerns into those of *all* rape victims, and those of victims that had been raped within the past five years (1987-91). The following results highlight which concerns do and do not change:

- *Her family knowing she was sexually assaulted*. This concern has not changed dramatically. Seventy-one percent of *all* victims and 66 percent of victims within the past five years are concerned about their families finding out about the rape.

- *People thinking it was her fault or that she was responsible*. Rape victims are still very concerned about being blamed for the rape, with 69 percent of *all* victims and 66 percent of recent rape victims saying they are concerned about this.

- *People outside her family knowing she was sexually assaulted*. Again, there is no significant difference. Sixty-eight percent of *all* victims and 61 percent of rape victims within the past five years are concerned about this.

- *Her name publicized by the news media*. Women who have been raped within the last five years are more likely to be concerned about the possibility of their names being made public than all rape victims (60% vs. 50%).

- *Becoming pregnant*. Sixty-one percent of recent rape victims, as opposed to 34 percent of all rape victims, are concerned about getting pregnant.

- *Contracting a sexually transmitted disease (not including HIV/AIDS)*. More than twice as many recent rape victims were concerned about the development of sexually transmitted diseases than *all* rape victims (43% vs. 19%).

- *Getting HIV/AIDS*. Recent rape victims were four times more likely to be concerned about getting HIV/AIDS as a result of the rape than *all* rape victims, regardless of the recency of the rape (40% vs. 10%).

The stigma still associated with rape is reflected in the high percentage of rape victims being concerned about people, such as family members and friends, finding out. Thus, from a victim service provider perspective, maintaining confidentiality and respecting the privacy needs of rape victims are important goals of service and assistance.

## The Need for a Comprehensive Response Protocol for Rape and Sexual Assault Victims

Rape victims have many needs, and improving the investigation and prosecution of rape cases cannot be accomplished by any single agency. In 1992, the Office for Victims of Crime provided support for a national-scope project to evaluate the system of multidisciplinary services that have been developed at the community level. *Looking Back, Moving Forward: A Guidebook for Communities Responding to Sexual Assault* (NCVC 1993) developed a "victim-centered" model for responding to rape victims. The report identified a number of agencies that should play a key role after a sexual assault occurs:

- Victim services.
- Medical.
- Mental health.
- Law enforcement.
- Prosecution.
- Courts.
- Institutional and community corrections.

The combined functions that each of these agencies provides to rape victims would create a model response to rape victims that accomplishes the following:

- Recognizes and supports the need of sexual assault victims to assume control over their own lives.
- Addresses the immediate short- and long-term mental health impact of the trauma.
- Provides accompaniment/transportation to emergency medical treatment and pays for all forensic rape examinations.
- Investigates vigorously all cases.
- Apprehends offenders and aggressively prosecutes cases in a timely fashion.
- Informs victims at each stage of the proceedings.
- Vertically prosecutes cases within prosecutors' offices.

- Gives victims the opportunity to express a preference for what they would like to see happen to the offender.

Victims who report rapes to law enforcement will likely have contact with medical, victim service, and law enforcement professionals. If an arrest is made, prosecutors become involved. If there is a conviction, then institutional or community corrections becomes involved. The NCVC report strongly advocates establishment of community sexual assault interagency councils with representation of all these professionals and agencies. The report also argues that these interagency councils should negotiate a multiagency/multidisciplinary protocol specifying how sexual assault cases should be handled.

Clearly, no agency can do the job alone. Although establishment of a community sexual assault interagency council is difficult and may be impractical in some communities, the importance of cooperation and teamwork cannot be overemphasized. Law enforcement is critically important, but law enforcement cannot succeed without the assistance and support of other agencies.

The United States and South Carolina have numerous police and prosecutorial jurisdictions. No one protocol can be developed that fits the needs of all these jurisdictions. It might be feasible to develop special sex crimes investigation units in large law enforcement agencies or in large metropolitan areas, but in small jurisdictions, this may not be feasible. Likewise, large metropolitan areas have many law enforcement agencies as well as major medical centers, rape crisis centers, and other victim service agencies. Small law enforcement agencies are often located in towns or rural jurisdictions that lack ready access to medical centers and to victim services. Large agencies often have victim advocates, but small agencies rarely do.

Thus, the major issues in developing a protocol in large metropolitan areas or in large law enforcement agencies are likely to be quite different than those in rural areas and in small agencies. Although victims' needs are the same and the elements of effective investigation and prosecution are the same irrespective of the jurisdiction, the protocol itself should reflect the circumstances within different jurisdictions.

## Specific Rights and Services for Victims from the Criminal and Juvenile Justice Continuum and Allied Agencies

The system for services and support for victims of rape and sexual assault should include emergency or crisis services, support throughout the criminal or juvenile justice system, and medical, mental health, financial, legal, or other types of support as needed.

In many communities across America, a system of responses takes place for rape victims who choose to report the crime to law enforcement. Rather than

looking at the response to rape victims in the traditional way (i.e., what each agency and/or individual should do for a rape victim), the "victim-centered" approach looks at the needs of the victim at each stage and recommends various agencies that could provide the needed service or support.

## ROLE OF THE FIRST RESPONDER TO RAPE VICTIMS

The first responder can be a hotline operator, a rape crisis center advocate, a police officer--all of whom must be trained in victim sensitivity and crisis response techniques, with a special focus on telephone communication skills. The basic victim assistance needs at this initial stage include the following:

- Determining if the victim needs any emergency medical care.
- Responding to the safety and security needs of rape victims--determining if the alleged assailant is still nearby and if the victim needs protection.
- Assisting with or providing transportation for the victim to the hospital.
- Advising the victim of the need to preserve evidence (by not bathing, showering, washing garments, etc.).
- Providing crisis intervention counseling, in person or over a hotline.
- If the victim requests a supportive person, obtaining a personal friend or professional to immediately join the victim.
- If the victim requests, staying on the phone or at the physical location with her.

The *First Response to Victims of Crime* handbook developed by the Office for Victims of Crime (January 2000) suggests that first responders be prepared for any type of emotional response by victims. First responders are cautioned to avoid interpreting a victim's calmness or composure as evidence that a sexual assault did not occur. The desire to forget details of a horrific crime is normal and should not be interpreted as resistance to giving a statement. First responders are instructed to be supportive without appearing overprotective or patronizing.

***Medical care following rape.*** Emergency medical care, especially the collection of evidence through a forensic examination, is critical for both the victim and the protection of evidence for prosecution. Medical care providers must fulfill two sometimes conflicting roles: they must meet the rape victim's medical and emotional needs, and they must collect evidence to be used in a legal proceeding. Comprehensive medical protocol in the aftermath of rape includes the following components:

- Collecting forensic evidence (rape exam) in a sensitive manner. As of July 1995, all states now pay for the cost of the exam. This exam includes an internal examination, pubic hair combings, nail scrapings, saliva samples, swabs for foreign materials on the victims' body, and an overall examination for bruises and lacerations and other physical trauma. It is one of the greatest sources for "secondary injury" in the aftermath of rape. It is very important to provide rape victims with a supportive person, a trained social worker at the hospital or a rape crisis intervenor from a local rape crisis program to accompany the victim during this exam. It is also important to let the victim know that it is her choice whether or not to have the advocate present.

- Obtaining the victim's complete medical history, including the date of her last period, contraceptive use, sexually-transmitted disease (STD) information. etc.

- Treating the immediate physical injuries of the victim.

- Diagnosing and treating sexually transmitted diseases.

- Conducting pregnancy tests, providing counseling, and providing drugs for terminating a potential pregnancy, if the patient wishes.

- Obtaining blood and urine samples for drug screening if medically appropriate (Speck 1999).

- Providing information about HIV/AIDS. A baseline HIV test immediately after the assault should be conducted, followed by repeated tests every three months for up to two years.

- Providing information about victim compensation.

Many hospitals across the country have established protocols on treating sexual assault and rape victims. However, The National Women's Study asked victims if they had a medical examination following the assault. The study found the following:

- Only 17% of all rape victims were examined medically.

- 60% (of these 17%) rape victims were examined within twenty-four hours of the assault, and 40% were examined more than twenty-four hours after the assault.

- Two-thirds of rape victims told their doctors that they had been sexually assaulted; the remaining one-third did not.

In addition, many recommended practices and protocols did not occur in all rape examinations:

- 60% of rape victims were *not* advised about pregnancy testing or how to prevent pregnancy.

- 73% were *not* given information about testing for exposure to HIV/AIDS.

- 39% were *not* given information about testing for exposure to sexually transmitted diseases.

Despite some improvements in the dissemination of information about testing for pregnancy, HIV/AIDS, and sexually transmitted diseases to rape victims, the following conditions remain:

- The rate of nonprovision of information about pregnancy prevention to recent rape victims was similar to that reported overall (55% vs. 60%).

- 33% of recent rape victims were not given information about testing for exposure to sexually transmitted diseases as opposed to 40% of all rape victims.

- 50% of recent rape victims were not given information about testing for HIV/AIDS, despite the fact that rape clearly constitutes an unprotected exposure to bodily fluids of assailants with unknown HIV/AIDS status.

Sexual Assault Nurse Examiner (SANE) programs offer an innovative approach to handling the medical/evidentiary aspects of sexual assault and child abuse cases through the use of technology, nurse examiners, and specialized settings. Instead of having doctors handle these cases in busy emergency rooms, SANE programs create a special environment for victims and use trained nurse examiners to conduct the evidentiary medical examination and present the forensic evidence at trial. According to the Tulsa Police Department, the nationally recognized Tulsa SANE program has substantially improved the quality of forensic evidence in sexual assault cases.

The Sexual Assault Resource Service (SARS) of Minneapolis developed a guidebook entitled *SANE Development and Operations Guide* to be used by jurisdictions interested in developing SANE programs (Ledray 1999). This guidebook (available online for downloading at www.sane-sart.com) stresses the need for a community approach when developing the program. Some programs such as the Memphis Sexual Assault Resource Center have a free-standing location where only sexual assault victims are seen. This center has nurses and advocates on call 24 hours a day and a counseling program on site. Whether co-located in a single facility or, more commonly, located throughout the community, the collaboration of law enforcement, medical professionals, justice system and rape crisis programs is essential to meet the needs of rape victims.

***Rohypnol and other drugs used in rape.*** Rohypnol (roofies), Gamma Hydroxybutrate (GHB) and Ketamin have been termed "acquaintance rape

drugs." These drugs have been used to incapacitate potential sexual assault victims (Hindermarch and Brinkman 1999). Rohypnol, the best known of these drugs, is not approved for medical use in the United States. It is a benzodiazepine that was developed for use as a treatment for insomnia and as a pre-medication for anesthesia. Rohypnol has physiological effects similar to Valium although Rohypnol is approximately ten times more potent (DEA 1999).

Rohypnol has a hypnotic effect and sedation begins twenty to thirty minutes after ingestion. The effects peak at one to two hours and may persist for six to eight hours. The drug causes anterograde amnesia which means that the user remembers little about the time during which he or she is sedated. Another widely reported effect of Rohypnol is disinhibition (Smith, Wesson, and Calhoun n.d.). The combination of Rohypnol with alcohol increases its sedative and amnesic effects, making it the "drug of choice" for some rapists who use this drug on unsuspecting victims.

## LAW ENFORCEMENT

***Innovations in law enforcement-based victim assistance.*** The past two decades have been marked by two significant advances in law enforcement's response to rape cases:

1. The creation of specialized sex crime units to enhance the agency's efficiency and send a message to the community that the department is deeply committed to solving sex crimes.
2. The development of in-house victim/witness assistance units that review all reports, sort out the felonies, and contact each victim of a felony crime, usually by phone. Law enforcement-based victim assistance professionals make referrals to rape crisis centers, contact victims who have delayed reporting, and provide community education in rape awareness and prevention.

***Reporting rapes to law enforcement.*** New methods for reporting rape and for guarding victims' privacy have been developed over the last two decades in an attempt to increase victims' willingness to report crimes and to cooperate throughout the investigation.

In deciding whether to report the assault, a victim has the following options:

- Immediately file a report of the rape with law enforcement.
- Report the rape to hospital emergency room personnel (who may or may not be required by law to report the incident to law enforcement).
- Defer filing a report while further considering the issue.

- Tell a friend, relative, therapist, or rape crisis center counselor, requesting that the person not report the assault.

- Not report the crime to anyone (Epstein and Langenbahn 1994, 17-25).

***Interviewing rape victims.*** Victims are now interviewed at different stages and with new techniques. In *The Criminal Justice and Community Response to Rape*, a checklist for law enforcement officers who are conducting initial interviews with rape victims, developed by the King County (Washington) Prosecuting Attorney's Office, is offered (Ibid.):

- Approach the victim in a gentle, supportive manner, bearing in mind the physical and psychological damage s/he has endured. Be patient and nonjudgmental.

- Assure the victim that s/he is safe now, and that you are there to help him/her.

- Avoid any forceful or aggressive behavior [that] might be threatening to the victim.

- Minimize unwarranted attention and publicity. Protect the victim's anonymity.

- Protect the victim from unnecessary questioning by other police officers and afford him/her whatever privacy is available.

- Request that the victim . . . not wash or douche and explain the rationale for this instruction (it may destroy physical evidence).

- Avoid in-depth questioning of the victim unless you will be assigned to conduct the entire investigation. However, do obtain a physical description [of the suspect], clothing . . . vehicle, if any, direction of flight, and type of weapon if the suspect is armed.

- Transmit a radio alarm for the suspect based on this description.

- Include in the supplement to the initial report a specific description of the victim's physical and emotional condition, any injuries, damage to clothing, and any information [that] will be of value in establishing proof of . . . [force].

- Accompany the victim to [a] hospital or personal doctor of her or his choice. Explain procedures in order to demystify the medical procedures and put her or him more at ease.

- If necessary, inform hospital emergency personnel or doctors of the importance of an internal and external examination and of what police

evidentiary needs are: semen slide from site of penetration as proof of penetration, and documentation of any bruises or injuries and overall physical and emotional condition as proof of forcible copulation.

- Ensure that the victim is treated for possible pregnancy and venereal disease.

- If the victim has visible scars, marks, or bruises, take photos. If marks or bruises are in [the] genital area, have them taken by [a] nurse or female police officer (if the victim is female).

- Obtain a rape kit from [the] doctor and deliver to [the] lab for analysis.

- Take the victim's garments and other stained or torn objects for [a] semen and blood analysis, and as proof of force and penetration. Make sure all the garments worn during and after the assault are accounted for. If the assault occurred on a bed, take the bedclothes. Place garments and other items in clean paper sacks to avoid contamination during transport and storage.

- If [an] arrest is made soon after the crime, examine the defendant's clothing and underwear for rips [and] blood or semen stains and note his general condition. Take pictures of him, if possible.

- Carefully note any statements or admissions by [the] defendant.

- Advise the victim of available counseling groups and other victim services. Make sure a victim/witness advocate has been contacted.

- Remember that the actions of the first officer on the scene may have a vital impact on the future psychological well-being of the victim. Every effort should be made to relieve feelings of shame or guilt, and to treat the victim with a sense of dignity and professionalism [that] will aid her or him on the road to recovery and . . . help her or him to regain self-esteem.

In addition, extensive experience of victim advocacy from the law enforcement perspective points out the need to:

- Begin the interview and investigation with a general statement which clarifies that while some of the questions may *appear* to be judgmental or blaming, they are not intended to be so; they are simply necessary to conduct the most thorough investigation possible.

- Advise victims of the state compensation program, and provide forms for completion (as well as referrals to advocates who can assist with securing compensation).

- Implement a strong policy that protects the identities of rape victims from the media, coordinating such privacy protection efforts with the police public information department, rape advocacy organizations, and the news media.

- Coordinate rape victim support efforts with rape crisis centers, ensuring that the victim is advised of the availability of immediate support and advocacy and, upon request, contacting a rape counselor or advocate to go the crime scene or hospital.

- Coordinate the prompt return of property that is used as evidence with the prosecutor's office.

  For example, a rape victim who was sexually assaulted in her bedroom wanted to know when she could get her bedspread back from the police. Both the law enforcement agency and victim advocate in the case wrongfully made the assumption that she would not be interested in ever seeing the quilt again. However, since the bedspread matched the decor of her room that she had taken great pride in decorating, the victim was eager to have this evidence returned.
- Provide information about victim compensation and referrals to agencies or professionals who can help process the application.

The information obtained by law enforcement in its initial and ongoing investigation is critical to the district attorney's decision whether or not to prosecute. As such, the collection and monitoring of law enforcement information should be closely coordinated with prosecutors' offices.

## PROSECUTION

Some solicitors utilize a vertical prosecution approach to rape cases, with prosecutors who are specially trained in sexual assault case management. The same prosecutor handles a case from the investigation through the decision to prosecute to the verdict and sentencing, when applicable. In many jurisdictions, specialized units--which include investigators, prosecutors, and victim advocates--serve to further streamline the prosecutorial process, and ease the trauma of the victim in rape cases.

***Roles and responsibilities of prosecutors relevant to rape victims.*** Upon initial contact with a rape victim, prosecutors should explain their specific roles and responsibilities in the criminal or juvenile justice continuum. These include the following:

- Prosecutors should ensure that victims have received information about victim compensation and assistance in completing and processing the forms.

- Prosecutors should coordinate with law enforcement and medical professionals to limit the number of times a rape victim must be interviewed for a case.

- Victims should be notified of all relevant criminal or juvenile justice proceedings and, when allowable under law, be allowed to attend such proceedings.

- The availability of "no-contact" orders should be explained to victims, and prosecutors should help victims who want such protection by requesting protective orders on their behalf from the court.

- Prior to any plea agreements, prosecutors should receive input from the victim.

- In cases of plea agreements, victim impact statements are particularly important. If a defendant pleads to a lesser assault charge, it is very important for the court to know the extent of the physical, psychological, and financial damages the victim endured, regardless of the plea bargain.

- Prosecutors should always take appropriate measures to protect the victim's identity from the media and the public.

- Prosecutors should request that the court allow a supportive person--such as a relative, friend, or victim advocate--to accompany the victim to all court proceedings upon request or as needed.

- Rape shield laws available in all fifty states and at the federal level--which prevent the defense from delving into the past personal and/or sexual history of the victim--should be enforced at all costs. Any motion to admit such evidence must be vigorously opposed by prosecutors.

- Prosecutors can seek expert testimony of medical professionals to explain physical trauma and mental health professionals to explain rape trauma syndrome, posttraumatic stress disorder (PTSD), and rape-related PTSD to the court.

- In cases of trials (or adjudication hearings in juvenile court), rape victims should have the opportunity to submit victim impact statements to the court prior to sentencing, either by addressing the court in person (allocution) or in writing, by audio tape, or by video tape. Victim service providers, prosecutors, and often probation officers are the key professionals in coordinating the use of the victim impact statement.

- Any special conditions of sentencing requested by the victim--such as protective orders, restitution, testing for HIV (with the results provided to victims in states that allow this by statute), and sex offender treatment--should be presented to the court at sentencing.

- In cases that result in prison or youth detention sentences, or "findings," prosecutors should provide victims with information about how to register to be notified of an offender's status, potential release, or release from state institutional corrections or parole agencies.

- In cases in which the prosecution does not have enough evidence to indict the offender, it is important to carefully explain this decision to the victim. Victims may interpret the lack of prosecution as a justice system failure. If the prosecutor believes that the victim was assaulted, but cannot proceed because of evidentiary or other legal reasons, this should be explained to the victim in an effort to minimize the "secondary victimization" at the hand of the legal system. Support persons of the victim's choosing, such as a family member, friend or victim advocate, should be able to attend these and any other conferences with the prosecutor.

**VICTIM SERVICES**

One of the goals of providing assistance to rape victims is helping them to gain a sense of empowerment. It is important that advocates and mental health professionals encourage victims to regain a sense of control in their post-rape lives. Since victims frequently blame themselves for the assault, it is important for victim advocates to remind victims that, even if there were choices within their control that could have contributed to greater personal safety, they are *in no way* responsible for the fact that they were sexually assaulted.

On the other hand, victims may have limited control of the aftermath of a reported rape. Advocates can assist victims by explaining the justice system processes. Frequently an arrest is not made or is made more slowly than a victim would prefer. Sometimes cases are not prosecuted due to insufficient evidence. Advocates can help victims overcome these hurdles by giving them accurate information and coordinating meetings with law enforcement, prosecutors, and correction officials. Knowing they have been heard by the "system" is essential for victims, as it often allows them the comfort of knowing that they did everything possible to promote their desired outcome.

Sexual assault advocates may be paid professionals or trained volunteers who are committed to working with victims. They share the common goal of assisting victims as they navigate through the horrific aftermath of an assault. Sexual assault advocates:

- Maintain a victim-centered approach to the delivery of assistance.

- Provide the victim with information needed to make informed choices.

- Make appropriate referral for counseling and other community services, such as HIV/STD testing.

- Provide information and support from the time of report, through adjudication, and post sentencing.
- Provide counseling for the victim, family members and/or significant others or make referrals to appropriate resources.
- Work with allied professionals to protect the privacy of the victim in the news media.

The specific duties of victim advocates differ depending on the setting. Advocates at a rape crisis center may--

- Answer hotline calls from victims.
- Give victims information about how to report an assault to police.
- Assist the victim in determining whether or not she or he wishes to report.
- Make referrals for crisis or long-term counseling.
- Meet victims at an emergency room or hospital and offer to be present during the medical/forensic exam.
- Provide information regarding victim compensation.
- Serve as a liaison for the victim with law enforcement and the criminal or juvenile justice system.

Advocates who work within a law enforcement agency may--

- Accompany the victim for a rape exam.
- Attempt to contact victims who have not followed through with a report.
- Ensure that victims are interviewed in a private setting.
- Work to ensure the victim's anonymity.
- Coordinate services with a rape crisis center if there is one in the area.
- Make referrals to meet victims' social service needs.
- Make referrals to counselors trained to work with victims.

Advocates who work for the prosecutor may--

- Notify victims of upcoming court dates and let them know when and if they can attend.

- Let the victim know that he/she can be accompanied to court by a support person or by the advocate if desired.
- Assist the victim in developing a victim impact statement.
- Ensure that victims have a private waiting area prior to testimony.
- Ensure that the victim's wishes regarding interaction with the news media are respected.

Advocates who assist victims, post-conviction/adjudication, may--

- Interface with probation/parole officers if asked to do so by the victim.
- Articulate the victim's wishes regarding implementation of core rights, including notification, restitution, and protection.
- Ensure that the victim receives notification of the status change of the offender, if desired.
- Assist victims with developing a letter or statement regarding victim impact to be sent to the parole board.
- Offer to accompany victims to parole hearings to offer support.

The needs and desires of the victim should always be the advocate's primary concern. Advocates must be aware of confidentiality issues regarding victim interviews and statements and should make sure that the victims they serve are also aware of these limits.

When interviewing victims of sexual assault, it is critical to clearly define terms when discussing rape or sexual assault. The victim's culture will influence what acts he/she considers to be beyond the cultural norm, thus to be labeled as an assault. Key words become even more important when interviewing non-English speaking victims. Words that translate the same into English may have different connotations depending on the victim's experience or country of origin. For instance, *rapto* and *violacion sexual* are words that mean *rape* in Spanish. Their idiomatic meanings differ dramatically and can alter the meaning of an interview question depending on the victim's understanding of the phrase (Lira, Koss, and Russo August 1999).

Advocates who are not mental health professionals should develop relationships with mental health practitioners in the community to facilitate referrals. An advocate's ability to network within the law enforcement and social service communities can provide victims with timely, appropriate services to meet needs that might not otherwise be addressed.

## JUDICIARY

In the past decade, substantial progress has been made to provide judges with training and resources that can help them handle rape cases in the most sensitive manner possible. Through efforts sponsored by the Office for Victims of Crime, Violence Against Women Office, National Coalition Against Sexual Assault, The National Judicial College, and others, many curricula have been developed and taught to the judiciary to heighten their awareness of the special needs of rape victims.

***Roles and responsibilities of judges relevant to rape victims.***

- Upon request, judges should issue "no-contact" orders or other measures of protection requested by the victim.
- In *voir dire*, judges must take extreme caution and allow prosecutors to assess any attitudes among potential jurors that might tend to "blame the victim," or contribute to misunderstandings about the nature and extent of sexual assault crimes.
- Judges should close all court proceedings involving rape cases to the media and the general public.
- Persons supportive of the victim should be allowed to be present with him or her in the courtroom.
- Expert witnesses called by the prosecution can be utilized to better explain psychological and physical traumas experienced by rape victims.
- Victim impact information should always be solicited in cases involving diversion, plea agreements, or jury/judge verdicts. The use of victim impact statements can be enhanced by close coordination among prosecutors, probation, and the judiciary. Any victim impact information should be included in the offender's file (in a confidential section that prevents access by the offender and/or his or her counsel) that is forwarded to probation, corrections, and/or parole.
- Any special conditions of sentencing requested by the victim--such as HIV testing, restitution, protective orders, or specific offender treatment--should be given serious consideration by judges.
- The imposition of restitution and fines should be mandatory in all rape cases, with judges considering the long-term financial impact of the crime on victims who may have future expenses related to medical needs, counseling, relocation, time lost from work, etc.

## PROBATION

Cases involving plea bargains or court sentences to probation or diversion are handled by probation departments. Victim sensitivity on the part of probation officials and consideration of victims' rights and needs are essential components of probation-based victim services.

***Roles and responsibilities of probation relevant to rape victims.***

- Victim impact information should be incorporated as a component of presentence investigative reports (PSIs) in all sentences that result in probation.

- Any special conditions requested by the victim should be considered and implemented in accordance with law. These might include protective orders; sex offender treatment; alcohol or other drug abuse treatment; and HIV testing or testing for sexually transmittable diseases (with the results provided to victims in jurisdictions where this is a statutory right).

- Restitution to rape victims should be given priority over other fines levied against probationers. Probation officials should assess the long-term financial losses that victims might incur, make appropriate recommendations, and coordinate operational systems with the court that collect and disburse restitution payments to rape victims.

- If victims request to be notified of probation violations, they should be contacted when/if such infractions occur. In jurisdictions that allow victim input at violation hearings, victims should be notified of this right, and be allowed to testify if they wish.

- If victims express a desire to participate in victim/offender programming (such as mediation or victim impact panels), their wishes should be fulfilled.

## CORRECTIONS

Over the period from 1985 to 1993, there has been only slight variation in the average sentence received for rape and sexual assault by those entering state prisons. Entering prisoners convicted of rape have received sentences averaging between twelve and thirteen years, while those convicted of sexual assault have been admitted to prison with sentences averaging between eight and nine years. There is no evidence from national data on those admitted to state prisons that the average sentence for either category of crime has been lengthened.

National data on sex offenders discharged from state prisons between 1985 and 1993 reveal two distinct trends: an increase in the average length of stay; and an

increase in the percentage of the sentence served in confinement prior to release (Greenfeld 1996, 19).

Nearly all of America's state correctional agencies and the Federal Bureau of Prisons have victim service programs that provide information, notification, and referrals to victims and witnesses. Victim service providers should be aware of the specific rights and services that are mandated by law and/or by correctional agency policy to be able to best inform and serve victims of rape.

***Roles and responsibilities of corrections relevant to rape victims.***

- In classifying offenders (to determine their location, level of security, and program assignments), corrections should review all victim impact information contained in the offender's file.
- All victim information in offender's files should be confidential, with "flags" for privacy on paper files, and security screens in automated databases.
- In cases where HIV testing of convicted offenders is a component of the court order, corrections agencies should coordinate the testing and release of test results (where allowable by law) to victims.
- Although sex offender treatment programs are available on a very limited basis, they should be mandatory to the extent possible for convicted rapists.
- Restitution orders from the court should be enforced with payments provided to rape victims in accordance with state law and/or agency policy.
- Correctional agencies that collect restitution from inmates should coordinate the prompt disbursement of monies to rape victims.
- Upon request, victims should be notified about changes in the offender's status, such as movement to a lower-level security institution, pending release, release, escape, or death.
- In instances where correctional employees are sexually assaulted by inmates, Departments of Corrections should have protocols, policies, and programs in place that provide for immediate and long-term support and services for the victim.

## PAROLE

Sensitivity to rape victims' needs--from both paroling authorities, parole boards, and parole agents--is essential to avoid compounding victim trauma. The potential release of a rapist is a terrifying prospect to most victims. Paroling

authorities and personnel should be knowledgeable about the long-term effects of rape, especially responses that might be "triggered" by parole or parole release hearings (such as rape-related PTSD). It is interesting to note that in several states, a rape victim serves as a member of the parole board.

***Roles and responsibilities of parole relevant to rape victims.***

- When allowed by statute, victims should be notified of parole hearings and of any rights they have relevant to such hearings (such as participation, attendance, and providing victim impact information). Support persons including family members, friends, and victim advocates should be allowed to accompany victims to hearings.

- Victim impact information from sentencing should be included in offenders' files that are reviewed by paroling authorities.

- Victim impact statements at parole should be allowed in five forms: allocution, written, audiotape, videotape, or teleconferencing. Victim impact statements provided at the time of any parole or release hearings should be compared to the initial victim impact statement provided at the time of sentencing. When permitted by law and upon request from the victim, the delivery of impact information should be confidential.

- Parole boards should consider any reasonable requests from rape victims relevant to the offender's release or supervision, including but not limited to: protective orders; commitment to a geographical area that is not in the victim's community; when allowed by statute, HIV testing (with the results provided to victims upon request); sex offender treatment; abstinence from alcohol and/or other drugs; special monitoring (such as electronic monitoring); and restitution.

- Upon request, rape victims should be notified if the offender in any way violates the conditions of parole and should be allowed to submit victim impact information at parole revocation hearings.

- Contact information for the convicted rapist's parole agent should be provided to the victim, including how someone in the paroling authority can be reached twenty-four hours a day.

Clearly, the criminal or juvenile justice continuum for rape victims requires concerted, ongoing, multidisciplinary efforts that focus on reducing the amount of trauma a victim will have to endure throughout the system. Education for all system professionals about the psychological, physical, and financial effects of rape--as well as how these effects can be compounded by participation in the criminal justice process--should be incorporated into orientation and continuing education programs for all professionals. Involvement with and reliance on the

many valuable services offered by victim service providers are essential to guaranteeing a continuum that is sensitive.

## The Management of Sex Offenders in the Community

On any given day, there are approximately 234,000 offenders convicted of rape or sexual assault under the care, custody, or control of corrections agencies; nearly 60 percent of these sex offenders are under conditional supervision in the community (Greenfeld 1996). A relatively recent public policy phenomenon in the United States has focused national and community attention on managing sex offenders in the community, with an emphasis on public protection and reduction in recidivism. Two significant initiatives have emerged as a result: the implementation of sex offender community notification laws, and sex offender monitoring by community corrections agencies that recognizes the rights and needs of communities and the victims. Both initiatives merit the attention and involvement of victim advocates.

### SEX OFFENDER COMMUNITY NOTIFICATION LAWS

In 1996, federal legislation mandated that all states establish a community notification program or lose ten percent of their federal law enforcement funding under the Byrne Memorial State and Local Law Enforcement Assistance Funding program. As of October 1997, forty-seven states had passed "community notification" laws that require law enforcement agencies to inform local communities that convicted sex offenders are residing in their neighborhoods or allow public access to this information.

Community notification laws allow or mandate that law enforcement, criminal justice, or corrections agencies give citizens access to relevant information about certain convicted sex offenders living in their communities. These laws are distinct from sex offender registration laws, which require convicted sex offenders who are living in the community to notify police officials of where they are living. They are also distinct from victim notification laws, which mandate that crime victims who wish to receive information about the criminal justice processing or release status of the person(s) who victimized them are provided with it.

Provisions of community notification laws vary state to state. States differ in their methods of informing the public of a sex offender's presence in their community and the extent of the information they provide. Some states proactively inform the community, while others make information available to citizens upon request. Those states using community notification laws have essentially established four notification categories:

- *Broad community notification* (18 states) releases information about sex offenders to any person or organization who requests it.

- *Organizational notification* (14 states) informs organizations that are especially vulnerable to particular offenders such as day care centers and schools.

- *Individual notification* (13 states) informs victims and classes of victims of the presence of specific offenders in the community.

- *Police notification* (14 states) allows persons or organizations to obtain sex offender registry information from local law enforcement.

Typically, individuals and organizations get offenders' names, photos, crime descriptions, and age(s) of their victim(s). Information is often provided on how offenders target their victims as well as their modus operandi. Some notifying agencies may also provide community members with information about the nature of sexual offending, the characteristics of sex offenders, methods of self- or community protection, and information about what can be done when one learns that a sex offender is living in their neighborhoods.

> (The preceding material in this section is derived from "An Overview of Sex Offender Community Notification Practices: Policy Implications and Promising Approaches" published by the Center for Sex Offender Management (CSOM) in November 1997.)

The role of victim service providers in community notification efforts includes the following:

- Obtaining information about statutory mandates for community notification and the processes that are utilized in the state to fulfill such mandates for incorporation into their community outreach and victim assistance resource materials.

- Providing information to victims of rape and sexual assault about community notification laws, processes, and any specific rights relevant to victims.

- Collaborating with justice agencies (such as law enforcement and probation) that are responsible for community notification and offering assistance in developing public education, community protection, and information/referral resources.

- Participating in any community forums related to either community notification of a specific offender(s), or the issue of community notification in general.

- Utilizing community notification processes as an opportunity to publicize the availability of supportive services and assistance for reporting and nonreporting victims of sexual assault.

## MONITORING/MANAGING SEX OFFENDERS IN THE COMMUNITY

With the majority of convicted sex offenders residing in communities, significant efforts in many jurisdictions have resulted in a "containment approach" that includes community protection and victim advocacy as well as the supervision, evaluation, and treatment of sex offenders under community supervision. Leadership from the Maryland-based Center for Sex Offender Management, with support from the U.S. Department of Justice, has provided extensive training and technical assistance that incorporates both input and involvement of victim service professionals.

Collaborative efforts among probation and parole agencies, law enforcement agencies, sex offender treatment professionals, and victim service providers are crucial to the containment approach to managing sex offenders in the community. The specific roles of victim advocates are best illustrated by a model program in Connecticut entitled S.A.F.E.-T. (supervision, advocacy, follow-up, and treatment). A sexual assault victim advocate participates in the S.A.F.E.-T. Intensive Sex Offender Unit, and provides for victim and community safety by facilitating increased input, involvement, and cooperation from victims, their families, and the community at large.

The victim representative on the team does the following:

- Educates victims and the community about the intensive probation unit.
- Establishes a communication link with the victim, when possible, to provide information/ feedback from the victim to the unit, including valuable information about the offender's behavior.
- Keeps the victim informed of the offender's status.
- Provides direct services to victims and family members who are experiencing trauma when the offender is released into the community.
- Speaks to community groups to promote broad community involvement as part of the offender supervision network.
- Provides information about risk reduction and available community resources to community groups.
- Assists with the community notification process.
- Provides information and support to community members with concerns about the community notification process.
- Works with the intensive probation unit on home visits and field visits.

- Shares with the team information about any behavioral violation gathered by the community or the victim.
- Participates in offender treatment programs, including counseling groups and victim empathy segments.
- Provides information and training about victim issues.

Effectively managing sex offenders in the community with an emphasis on victim and community protection requires the commitment and collaboration of victim service providers. By making victims' rights and interests a top priority and providing information and assistance to victims and the community, victim service providers have a valuable and vital role in community-based sex offender management processes.

## Significant State Statutory Provisions

Many statutory changes have been enacted across the states to address all forms of sexual assault and rape. The following are two significant reform measures that pertain to victim service providers:

### MARITAL RAPE

Prior to the passage of these laws, "rape" within a marriage or co-habituating relationship was not considered rape. In the 1980s, a California legislator shocked many citizens when he asked, "If you can't rape your wife, who can you rape?" Today, most states have reformed this exemption, making marital rape a specific offense, but exemptions still exist in some states.

### PRIVILEGED COMMUNICATION FOR VICTIM COUNSELING

For many rape crisis advocates and interveners, the issue of confidential communications with rape victims has been one of their most frustrating and ongoing challenges. Without the protection of client/professional confidentiality granted to licensed mental health professionals such as psychologists or social workers, some rape crisis workers have faced subpoenas and have even been jailed on contempt charges for refusing to divulge the substance of their conversations with rape victims.

As early as 1982, the President's Task Force on Victims of Crime selected privileged communication between rape and domestic violence advocates and victims as a top priority for legislative change.

It is important to note that rape crisis advocates working in criminal or juvenile justice-based agencies (law enforcement/prosecution) are *not* covered by this confidentiality protection due to discovery rules (their communications may contain information that is helpful to the defense). It is also important to note that

OVC's *New Directions* reiterated the need for this legislation (OVC 1998). Unfortunately, South Carolina has not enacted legislation providing privileged communication for victim counseling.

## Significant Federal Laws

Within the last decade, significant federal laws have been enacted that address rights for sexual assault victims, new classifications of sexual crimes, and funding and support for the criminal justice response to sexual assault.

### THE HILLORY J. FARIAS AND SAMANTHA REID DATE-RAPE PROHIBITION ACT OF 1999

The Hillory J. Farias and Samantha Reid Date-Rape Prohibition Act of 1999 was signed into law on February 18, 2000 to modify the schedule of the Controlled Substances Act (CSA) to criminalize the manufacture, distribution, or possession of gamma butyrolactone (GBL), a "designer drug" associated with date rape and other forms of sexual assault among young adults. Public Law No. 106-172 directs the Attorney General to develop model protocols for taking victim statements in connection with investigations into and prosecutions of violations of the CSA, and other federal and state laws that result in rape or other crimes of violence. It directs the Secretary of Health and Human Services to submit annual reports to Congress that estimate the number of incidents of abuse of date-rape drugs, and requires them to develop a national campaign to educate young adults, law enforcement personnel, nurses, hospital emergency room personnel, and rape crisis counselors on the dangers of date-rape drugs, recognizing the symptoms in a victim and developing appropriate responses. (Public Law No: 106-172, The Hillory J. Farias and Samantha Reid Date-Rape Prohibition Act of 1999, February 18, 2000.)

### THE HIGHER EDUCATION AMENDMENTS OF 1998

The Higher Education Amendments of 1998 to the Higher Education Act expands rights of victims of crime on campuses and increases the reporting responsibilities of institutions to include crimes committed on campus, off campus, on public property, and in residential facilities for students. There are specific provisions that pertain to perpetrators and victims of sexual violence as well as grant funding to combat violence against women on campus and $1 million to conduct a study on how colleges respond to complaints of sexual assault.

### DRUG-INDUCED RAPE PREVENTION AND PUNISHMENT ACT OF 1996

This federal statute provides for penalties up to twenty years in prison for the intent to commit a crime of violence (including sexual assault) against an

individual by distribution of a controlled substance to that individual without his or her knowledge.

## THE VIOLENCE AGAINST WOMEN ACT OF 1994

The Violence Against Women Act (VAWA) offers an important source of new funding for programs that address the needs of sexual assault victims. While this law has been described in other chapters, it is important to point out that for victims of sexual assault, certain provisions of the act are pertinent:

- Under this Act, to qualify for the available funding, states have to pay for forensic rape exams.
- Federal funding is providing for coordination, investigation, and prosecution of crimes against women.

Appropriated and authorized funds to implement provisions of the Violence Against Women Act for domestic violence and rape prevention and intervention programs represent a significant increase in federal support. However, a key provision of the Violence Against Women Act that could allow female victims to bring a civil action for damages against their attackers in federal court has been struck down both in *U.S. v. Morrison* and most recently in the case of Christy Brzonkala on May 15, 2000 in the U.S. Supreme court. The 5-4 ruling dismissed the case of Brzonkala, a rape victim and former student at Virginia Polytechnic Institute. The Court majority ruled that Congress, in enacting the civil remedies provision, had overstepped its authority to regulate interstate commerce and enforce the equal protection guarantee of the U.S. Constitution. In so doing, the justices rejected the argument that states are not doing enough to protect rape victims and that gender-based violence restricts women's choices in jobs and travel. Writing for the minority, Justice David Souter cited "the mountain of data assembled by Congress, here showing the effects of violence against women on interstate commerce. . . . Violence against women may be found to affect interstate commerce and to affect it substantially" (www.findlaw.com/casecode/supreme.html).

## THE CAMPUS CRIME SEXUAL ASSAULT BILL OF RIGHTS OF 1992

Because of a nationwide problem of sexual assault on college campuses--which was traditionally handled by campus security, rather than through outside law enforcement (and as a criminal justice matter)--and because very often there was pressure on the student-victim not to report to outside authorities, a Bill of Rights became necessary for college rape and sexual assault victims. In addition to requiring that campus authorities treat rape victims with respect, give them information about their criminal and civil justice options, and establish procedures for assisting victims, rape prevention education is required.

## THE STUDENT RIGHT-TO-KNOW AND CAMPUS SECURITY ACT OF 1990

Due to a long tradition of handling crime on campus internally and not reporting crimes to local law enforcement, the extent of campus crime across the country was underreported for many years. Rape is among several on-campus crimes that now must report to local law enforcement under this law. Equally important, the law requires colleges and universities to provide information on safety-related procedures for the student.

## THE HATE CRIME STATISTICS ACT OF 1990

This law requires the reporting of crimes that are motivated by prejudice, race, religion, sexual orientation, and ethnicity. Women are not considered a "protected class" under the law; however, information is collected about crimes against women within protected categories. For the first time on a nationwide basis, sexual assault and rape statistics covering many types of overlooked crimes are being collected. This information will help target services and funding for previously undocumented and often unrecognized crimes against women.

### Promising Practices

- The *Rape Treatment Center* (RTC) at Santa Monica-UCLA Medical Center is nationally recognized for its exemplary treatment, education, and prevention programs. Established in 1974, the RTC has provided care for over 24,000 sexual assault victims. In April 1999, the RTC created a new, state-of-the-art clinic to enhance the treatment of victims in the immediate aftermath of a sexual assault. Historically, rape victims have received emergency services in hospital ERs. In these facilities, victims are often subjected to long waits and a chaotic environment, and as a result, the victim's trauma may be compounded and critical evidence deteriorates. The RTC's new clinic was designed to remedy these problems. Located within the hospital in a safe, private, therapeutic environment, the clinic is a 24-hour facility dedicated exclusively to sexual assault victim care. It is staffed by advanced practice nurse practitioners and professional therapists. The clinic uses advanced forensic equipment and technologies. In addition to medical and evidentiary services, victims receive crisis intervention and other advocacy and support services. Special health-related educational materials are provided. All of the services are free. In the development of the clinic, and in its ongoing operations, the clinic has collaborated with law enforcement agencies, crime labs, and other victim service providers. Contact: Gail Abarbanel (310-319-4000) www.911rape.org.
- In Montgomery County, Maryland, rape counselors were unable to find a rape crisis videotape in Spanish, so they developed their own. The twelve-minute video, produced with a $30,000 state grant and introduced publicly during 1999 National Crime Victims' Rights Week, features Spanish-

speaking people (a police officer, prosecutor, and rape counselor, among others) to explain what happens to the victim who reports a sexual assault.

- The *Anonymous and Confidential Internet Support Counseling Service* was initiated in March 1997 by the Brazos County Rape Crisis Center (BCRCC) in Bryan, Texas. It gives victims/survivors of sexual abuse or assault, their friends, and/or family members an opportunity to seek anonymous support counseling that is provided by a trained support counselor at the BCRCC. Victims and/or survivors anywhere in the world can access this technology and service. This technology allows users to electronically "write" to the BCRCC at any time (twenty-four hours a day, seven days a week) to request information or to seek help. Through the secure server, the user's identity and location are protected and are confidential. It allows users to tell or talk about their sexual abuse/assault without the fear of someone knowing who they are or from where they are calling.

**Sexual Assault Self-Examination**

1. Describe three major differences between the early legal definitions of sexual assault/rape and the reform definitions of the 1980s.

2. Describe two of the symptoms of rape-related posttraumatic stress disorder.

3. Select an agency within the criminal or juvenile justice continuum, and list five procedures and/or services that assist victims of rape.

4. Cite one of the most significant federal laws that has been passed to promote rape victims' rights and/or improve services.